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Slowing the Long-Term Growth of Social Security and Medicare

Without changes to federal programs for the elderly, the aging of the baby-boom generation will cause a substantial deterioration in the fiscal position of the United States government. The demographics are inexorable: the number of people age 65 and older will nearly double by 2030, while the number of adults under age 65 will grow by only about 15 percent. In addition to those demographic factors, the costs per enrollee in federal health programs are likely to grow much faster than inflation.

As a result, the amount that the federal government spends on its major retirement and health programs is projected to consume a substantial portion of what the government now spends on the entire federal budget. Beyond 2030, those pressures will intensify as longevity continues to increase and health costs continue to grow, so simply weathering the demographic surge of the baby-boom generation will not be enough to restore the federal government's fiscal posture to its recent norms. To accommodate such growth in spending, either taxes would need to rise dramatically, spending on other federal programs would have to be cut severely, or federal borrowing would soar.

In recent years, the Congressional Budget Office has made a number of long-range projections of spending. Those estimates are highly uncertain and very sensitive to even small changes in demographic and economic assumptions. Seventy-five-year projections prepared for this report merge CBO's assumptions for its current budget baseline for the next 10 years with the long-range demographic and economic assumptions of the Social Security and Medicare trustees. Like CBO's previous estimates, the 75-year projections reflect spending under current policies for the largest federal entitlement programs —Social Security, Medicare, and Medicaid. The projection for Social Security reflects growth in both the number of recipients and wages (the latter being the basis on which individual benefits are calculated). The projections for Medicare and Medicaid also reflect a growing number of recipients as well as higher costs for medical care. For those projections, the rise in health care costs per recipient is assumed to slow to a growth rate of 1 percentage point faster than gross domestic product per capita. While seemingly large, that rate is less than it has been in recent decades.

According to CBO's new long-range projections, which assume the current rules for benefits, outlays for Social Security, Medicare, and Medicaid will grow as a share of GDP by more than two-thirds by 2030, rising from 8 percent of GDP today to 14 percent. By 2050, outlays for the three programs could equal 17 percent of GDP and by 2075, 21 percent—exceeding the average shares of GDP absorbed by all federal spending and revenues over the post-World War II period.[1]

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1. For the purpose of the analysis presented in this chapter, the projected shortfall of dedicated taxes to finance Social Security and Medicare is ignored.

This chapter examines options for slowing the growth of Social Security and Medicare.[2] Compared with the spending trajectory under current law, the options would lessen the risk of unsustainable deficits and thus enhance the economic prospects of future generations. Of course, reducing the growth of Social Security benefits means lower future benefits than those currently scheduled under the law. However, the alternative of doing nothing could also mean lower benefits, given that the trustees for the two programs project that the Treasury Department's authority to spend for them will be curtailed abruptly—in 2030 for the Hospital Insurance part of Medicare and in 2041 for Social Security—as the programs' respective trust fund balances would fall to zero in those years. (As accounting devices, the trust funds reflect spending authority, and their balances allow the Treasury to make disbursements for the programs, but they do not provide the resources to make benefit payments.) Moreover, that scenario does not reflect the potential strain on overall budgetary resources that is likely to occur when the revenues that the Treasury receives for the two programs fall below their spending—which is projected to occur as early as 2010—and the possibility that having to constrain all other government activities will cause policymakers to curb Social Security and Medicare spending much earlier than the dates projected for the depletion of the trust funds. That gap between the programs' spending and revenues grows wider with time.

Any option to relieve the long-term fiscal pressures requires either substantially constraining the growth of benefits or raising the burden on future taxpayers. There is no free lunch in addressing the looming strains that Social Security and Medicare could create. Economic growth that is greater than what is currently projected could help mitigate the problem but by itself is unlikely to render a solution. Greater economic growth could result in higher incomes and thus higher tax receipts. But because expenditures for these two programs are driven in large measure by earnings in the economy (Social Security benefits are derived from an individual's wage

history, and much of Medicare spending is composed of labor costs), a larger economy will also result in higher spending for the programs. A significant advantage of a larger economy comes from the timing of the higher potential receipts vis-à-vis the higher expenditures. The higher tax receipts would be collected while people were working, whereas a substantial portion of the higher expenditures would arise later, during their retirement years. That timing advantage may help, but given the magnitude of the projected fiscal pressures, it is unlikely by itself to be sufficient to close the gap.

The advantage of acting sooner rather than later is illustrated by one of the options for Social Security discussed in the ensuing pages. Under the Social Security trustees' latest projections, in 2041 the system will lack 34 percent of the resources that it needs to fully cover its benefit commitments. If the rise in the level of initial benefits was constrained by roughly 1 percent each year starting with people who retire in 2029, the system would still lack 29 percent of the resources needed in 2041. If that restraint started 10 years sooner (that is, with those retiring in 2019), the gap in resources would be 26 percent. If it started in 2009, the gap would be only 14 percent, and if it started in 2004, the gap would shrink to 10 percent.[3] Thus, the sooner action is taken, the less likely will be the need for an abrupt increase in taxes or a cut in the benefits of *all* recipients, not just a constraint on the incremental rise in initial benefits of new retirees.

Social Security

In 2002, the federal government spent over $450 billion to provide Social Security benefits to more than 46 million retired or disabled workers, their dependents, and survivors. According to CBO's projections, under the current structure of benefits, spending will exceed the tax

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2. This chapter summarizes the situation for Medicaid; specific short-range options for that program appear in Chapter 2 on pages 128 to 133.

3. For the alternatives that would begin to constrain the rise in initial benefits before 2029, CBO assumed that the normal retirement age for Social Security benefits would not increase beyond age 66—thereby keeping the alternatives from resulting in a decline in the real value of benefits from one cohort to the next. Under current law, the normal retirement age is scheduled to rise gradually from age 66 to age 67 beginning with people who become eligible in 2017.

revenues earmarked for Social Security beginning in 2017. By 2030, total spending (in 2002 dollars) will reach about $1.2 trillion for 85 million beneficiaries. On average, beneficiaries will receive about $14,000 per year in 2030, compared with about $10,000 in 2002.

Three broad approaches for slowing the growth in spending for Social Security have received considerable attention. First, policymakers could alter the formula used to calculate benefits for newly eligible Social Security beneficiaries to constrain the increase in initial benefits from one cohort to the next. Second, they could increase the age at which workers became eligible for full benefits, referred to as the "normal retirement age," which also would constrain the increase in initial benefits. Third, they could reduce the cost-of-living adjustments that beneficiaries received once they were on the rolls. Specific options to illustrate both the strengths and the weaknesses of those approaches are presented below, along with estimates of the savings they could bring.

In general, workers are eligible for retirement benefits if they are at least age 62 and have had sufficient earnings on which they paid Social Security taxes in at least 10 years. Workers whose employment has been limited because of a physical or mental disability can become eligible at an earlier age with a shorter employment history. Various rules apply to family members of retired, disabled, or deceased workers.

If policymakers decide to slow the growth in Social Security benefits, equity and efficiency argue for enacting those changes long before they take effect. People view entitlement programs for the elderly and the disabled as long-term commitments between the government and the citizenry, and they may have based their behavior on current provisions. Deciding soon on any future changes in such programs and making gradual changes in spending and tax policies would give people more time to plan and adjust. The Congress set such a precedent when it amended the Social Security system in 1983. When policymakers raised the age at which retired workers could receive full benefits, the first workers affected by that change were then only 45 years old. By announcing the change so far in advance, the government gave them

the opportunity to take that new policy into account when planning for retirement.

Background on Social Security

Social Security is, by far, the federal government's largest income redistribution program, playing a critical role in supporting the standard of living of its beneficiaries. The Social Security system has two parts. The Old-Age and Survivors Insurance (OASI) program is the part of the system that provides benefits to retired workers, members of their families, and their survivors. The other part, Disability Insurance (DI), funds benefits for disabled workers younger than the normal retirement age and their dependents. OASI is by far the larger program: last year it accounted for about 85 percent of the spending for the two parts combined (referred to as OASDI). Benefits for both parts are financed primarily from payroll taxes paid by workers and employers on earnings covered by the OASDI program. The combined tax rate for 2003 is 12.4 percent of covered earnings—up to $87,000 annually.[4]

In confronting the impending imbalance between benefits and the revenues designated to pay for them, the Congress will need to decide what the Social Security system should attempt to accomplish and what legislative changes will be needed to ensure that the system achieves those goals for the baby boomers and subsequent generations. The current design of the Social Security system represents a trade-off between ensuring a sufficient level of benefits for the poorest beneficiaries and distributing benefits so that workers who have paid more taxes for Social Security receive more in benefits. The progressive benefit structure of the program reflects the attempt to balance those two objectives. Retired workers with a history of low wages receive benefits that replace a higher percentage of their preretirement earnings than do other

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4. For a fuller discussion of how Social Security works and how changes to the program might affect the nation's ability to deal with its impending demographic shifts, see Congressional Budget Office, *Social Security: A Primer* (September 2001).

retired workers. Nonetheless, workers who earned higher wages receive a higher level of monthly benefits.[5]

Approaches and Illustrative Options for Slowing the Growth of Social Security

To reduce the projected growth in spending for Social Security, legislation is needed to curtail the commitments made under current law. All of the approaches examined below have been proposed in recent years. The specific options shown here do not exactly replicate those approaches; they are designed more to show their generic forms. The estimates of savings are intended to indicate relative magnitudes of change.

Constrain the Increase in Initial Benefits. The most straightforward method of reducing the growth in Social Security spending is to slow the rates at which initial benefits rise from one cohort to the next. The effect of that approach would be to reduce the size of initial benefits going to each new group of eligible beneficiaries. The benefits awarded to them would still rise in nominal terms but only enough to keep up with inflation. That approach would not alter the benefits of those already on the rolls prior to its implementation.

Procedures under current law base the benefits of retired (and disabled) workers on their past earnings, expressed as an average level of earnings over their working lifetime —their average indexed monthly earnings (AIME). From that average, a formula calculates workers' primary insurance amount (PIA). The Social Security Administration then adjusts the PIA for a number of factors, such as reductions for early retirement, credits for later retirement, and increases for inflation.

The Social Security Administration bases workers' AIME on wages in employment covered by the Social Security program (up to the taxable maximum), with some adjustments. Earnings on which retired workers and their employers paid Social Security taxes are indexed to compensate for past inflation and real (inflation-adjusted) growth of wages. To convert the AIME to the PIA, the Social Security Administration applies a progressive formula in which the PIA replaces a higher proportion of preretirement earnings for people with low average earnings than it does for those with higher earnings.[6] The thresholds used in that formula are indexed to average annual earnings for the labor force as a whole. As a result of that feature, benefits for future recipients are designed to grow in real terms.

In general, workers will receive lower monthly benefits if they retire earlier than the normal retirement age. For example, workers who retire at age 62 in 2003 will receive a permanent 23 percent reduction. The size of that reduction is intended to be actuarially fair: the present value of the reduced monthly benefits that average workers could expect at age 62 is roughly equivalent to the present value of the full monthly benefits they could expect by delaying initial benefits until the normal retirement age (for example, 65 years and 8 months for workers age 62 in 2003). Similarly, workers who delay collecting benefits beyond the normal retirement age receive a credit to compensate them for the reduction in the length of time that they will receive benefits.[7]

Workers who had average earnings throughout their career and retired at age 65 in 2002 were eligible for an annual benefit of about $13,500, which replaced 40 percent of their previous annual earnings. Under current law, workers with average earnings who retire at age 65 in the future will receive benefits that will replace a smaller percentage of their past earnings. The scheduled increase in

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5. Even though the formula for calculating monthly benefits is progressive (in that it favors retired workers with low lifetime earnings), some people have questioned whether the overall benefit structure of the Social Security program is progressive. They point out that men with low lifetime earnings have shorter life spans, on average, than other men. Other people, however, observe that Social Security also provides benefits to the survivors of deceased workers and to disabled workers—features that contribute to the program's progressivity.

6. The following formula is used for workers who reach age 62 in 2003: PIA equals 90 percent of the first $606 of the AIME, plus 32 percent of the AIME between $606 and $3,653, plus 15 percent of the AIME over $3,653.

7. Starting with beneficiaries born in 1943, each year delayed beyond the normal retirement age will add 8 percent to their benefits. The delayed retirement credit for workers reaching the normal retirement age in 2003 is 6.5 percent.

the normal retirement age, discussed below, will produce most of the decline in the replacement rate.

Even with that decline, the real value of initial benefits will rise in the future as a result of the wage-indexing adjustments made in the calculation of benefits. An option that has received considerable attention would change the way benefits are calculated so that the real value of initial benefits would no longer rise. That option, which would link the growth in initial benefits to a price index, rather than to a wage index, would ensure that the purchasing power of future benefits was maintained, but it would no longer pass along gains in purchasing power that resulted from the growth of productivity in the economy. As a result, as long as average real wages continued to rise, the average replacement rate would fall for beneficiaries. Real benefits, however, would not decline.[8]

If such an option was implemented in 2009, each cohort of newly retired and disabled workers thereafter would receive benefits that were lower than what they would have received under the current rules. The difference would increase over time—cohort by cohort—with its size determined by how much real wages grew. If the growth of real wages was about 1.1 percent per year, for example, the projected impact on future benefits would be quite large. For example, workers becoming eligible for benefits in 2030 would receive nearly 20 percent less than they would under the current rules, and workers becoming eligible in 2075 would receive about 50 percent less. The value of the average benefits for each cohort would be similar to that for recent beneficiaries, but those benefits would replace a much smaller percentage of earnings. CBO estimates that adoption of this option would cut Social Security outlays in 2075 by about 40 percent from what they would be if benefits remained as currently prescribed.[9]

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8. To prevent real benefits from declining under this option, the normal retirement age was assumed not to increase beyond age 66.

9. The estimates for Social Security spending in this chapter are based on CBO's long-term simulation model (CBOLT). The version of the model used here is based on a methodology and assumptions about key economic and demographic factors similar to those used by the Social Security Administration's Office of the Chief Actuary.

Raise the Retirement Age. Under current law, the age at which workers become eligible for full retirement benefits (or the normal retirement age) is 65 years and 8 months for people reaching age 62 this year and will gradually increase to 67. For workers born before 1938, the normal retirement age was 65. That eligibility age increases in two-month increments for workers thereafter, reaching 66 for workers born in 1943. It remains at 66 for workers born from 1944 through 1954. It then begins to rise again, in two-month increments, until it reaches 67 for workers born in 1960 or later. Workers can still receive benefits at age 62, but with a larger reduction for taking them early (that is, prior to their normal retirement age).

Some Members of Congress and others have recommended that the shift toward the normal retirement age of 67 be accelerated and that the age be extended further thereafter. Proponents point out that people age 65 today are projected to live significantly longer than was the case in the early days of the Social Security system, that life expectancy is projected to continue to increase, and that that otherwise favorable development will raise the cost of the program.

Under the specific option illustrated here, the transition to the normal retirement age of 67 would be accelerated, followed by further increases so that the normal retirement age would keep up with assumed future increases in life expectancy (*see Table 4-1*). The normal retirement age of workers born in 1949 would be 67. Thereafter, the retirement age would increase by two months a year until it reached 70 for workers born in 1967. After that, it would increase by one month every other year. As under current law, workers would still be able to begin receiving reduced benefits at age 62, but the amounts of the reductions would be larger. This option would produce substantial savings in relation to projected spending levels under current law: by 2075, the savings would be about 20 percent.

As with the option to constrain the rise in initial benefits, raising the normal retirement age to keep up with future increases in life expectancy would shift the nature of the government's commitment somewhat. Debate about the level of Social Security benefits tends to focus on how much beneficiaries will receive each month rather than

Table 4-1.

Increase in the Normal Retirement Age Under Current Law and an Illustrative Option

Year of Birth	Year in Which Age 62 Would Be Reached	Year in Which Age 65 Would Be Reached	Normal Retirement Age	Reduction for Retirement (Percentage of PIA)	
				At Age 62	At Age 65
Current Law					
1943	2005	2008	66	25.00	6.67
1960	2022	2025	67	30.00	13.33
Illustrative Option[a]					
1943	2005	2008	66	25.00	6.67
1949	2011	2014	67	30.00	13.33
1955	2017	2020	68	35.00	20.00
1961	2023	2026	69	40.00	25.00
1967	2029	2032	70	45.00	30.00
1991	2053	2056	71	50.00	35.00

Source: Congressional Budget Office based on information provided by the Social Security Administration, Office of the Actuary.

Note: PIA = primary insurance amount.

a. Under this option, the normal retirement age of workers who turned 62 in 2011 would be 67. After 2011, the retirement age would increase by two months a year until it reached 70 in 2029, and then it would increase by one month every two years.

on how much they will receive over their lifetime. But because of increasing longevity, a commitment to provide retired workers with a certain amount of monthly benefits at age 62 in, say, 2030, is actually more costly than that same commitment made to today's recipients. Linking the normal retirement age with future increases in life expectancy is one way of dealing with that source of the program's rising costs.

For most purposes, this approach to constraining the growth in benefits is equivalent to cutting replacement rates. However, the benefits of workers who qualify for Disability Insurance would not be reduced. Consequently, older workers nearing retirement would have a somewhat stronger incentive to apply for DI benefits in order to receive a higher monthly amount. For instance, under current law, workers retiring at age 62 in 2029 would receive 70 percent of their PIA; yet if they qualified for DI benefits, they would receive 100 percent. Under this illustrative option for increasing the normal retire-

ment age, workers retiring at 62 in 2029 would receive only 55 percent of their PIA but would still receive 100 percent if they qualified for DI benefits. (To avoid increasing the incentive to apply for DI benefits, policymakers could narrow that difference—for example, by setting the benefits for workers who qualified for Disability Insurance at the level they would have received upon retiring at age 65.)

Reduce the Cost-of-Living Adjustment. Each year, the Social Security Administration adjusts monthly benefits by the increase in the consumer price index (CPI). For example, the 1.4 percent cost-of-living adjustment (COLA) effective for December 2002 was based on the increase in the CPI for urban wage earners and clerical workers (CPI-W) between the third quarter of 2001 and the third quarter of 2002. The basic level of benefits is raised by the percentage increase in the CPI-W beginning when workers become eligible for them, which for retired workers is age 62.

One way of reducing the growth in Social Security benefits is to reduce the automatic COLA. Some policymakers suggest that the law be changed to provide a COLA equal to the increase in the CPI minus a specified number of percentage points. To illustrate that approach, CBO estimated the effect of determining the COLA on the basis of the increase in the CPI minus 1 percentage point for December 2003 and thereafter. Doing so would reduce outlays by about 10 percent in 2075; most of that reduction (in percentage terms) would be achieved by 2030.

Unlike constraining the increase in initial benefits and raising the retirement age, this option of reducing the cost-of-living adjustment could be used to reduce the growth in the benefits of current beneficiaries and workers who will soon be eligible for Social Security. The estimated impact on monthly benefits for those first two options would progressively increase from one cohort to the next—either because of real wage growth or increased longevity. Thus, the baby-boom generation would incur a relatively small portion of the reductions in benefits. However, trimming the COLA would be one way of having the baby-boom generation and future generations share more evenly in the reductions.

Moreover, many economists believe that the CPI may overstate increases in the cost of living, but they disagree about the size of the overstatement. Devising a "true" cost-of-living index is problematic, and collecting and compiling data for such an index are difficult. For those reasons, economists have had trouble reaching a strong consensus on the issue. In 1996, the Advisory Commission to Study the Consumer Price Index (known as the Boskin Commission) concluded that the CPI probably overstated the change in the cost of living by between 0.8 percentage points and 1.6 percentage points a year.[10] Since the commission's report was issued, the Bureau of Labor Statistics has made several changes to the way that it calculates the CPI and has thereby eliminated some of the problems with the index. But some thorny issues remain, including how to measure the cost of living for

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10. Advisory Commission to Study the Consumer Price Index, *Toward a More Accurate Measure of the Cost of Living: Final Report to the Senate Finance Committee* (December 1996).

Social Security beneficiaries, whose purchasing patterns may differ from those of other consumers.

To the extent that the CPI still overstates increases in the cost of living for Social Security recipients, policymakers could reduce the COLA by a corresponding amount without making benefits any lower in real terms than they were when the recipients became eligible for the program. In contrast to an equivalent across-the-board constraint on the increase in initial benefits (or an equivalent increase in the normal retirement age), reducing the COLA generally would most affect the oldest beneficiaries and those who initially became eligible for Social Security on the basis of disability. Alternatively, lawmakers might choose to reduce the COLA of only those beneficiaries whose benefits or income was above specified levels, but doing so would reduce the savings. (Some beneficiaries with low income and few assets would receive Supplemental Security Income [SSI] benefits, which would offset some or all of the reduction in their Social Security benefits; the increased spending for SSI would help those beneficiaries, but it would also directly reduce the budgetary savings from this option by a small amount.)

The impact of even a relatively small reduction in the COLA would be quite large for older Social Security recipients in the future because their benefits would reflect the cumulative effects of a series of smaller adjustments tied to the cost of living. For example, if benefits were adjusted by 1 percentage point less than the increase in the CPI every year, beneficiaries at age 75 would incur a 12 percent reduction in benefits compared with what they would have received under current law; at age 85, they would get a 20 percent reduction; and at age 95, they would get a 28 percent reduction.

Conclusions About Social Security

Reducing the growth in spending for Social Security would require cutbacks in the commitments that the law currently prescribes. Constraining the rise in initial benefits, gradually increasing the normal retirement age, or reducing the cost-of-living adjustment could all produce substantial savings and still preserve the basic benefit structure of the Social Security system. Each of the options would also improve the outlook for the program's finances (*see Box 4-1*).

Box 4-1.

Impacts of Illustrative Options on Social Security's Finances

When considering questions about the financial status of the Social Security program in isolation, analysts often use three measures. One looks at the relationship between the program's costs and income in any given year, as measured by the projected gap between the two, expressed as a percentage of payroll subject to the Social Security tax, focusing on the first year in which projected annual costs exceed projected revenues (other than interest). Another measure is the first year in which the combined Social Security trust funds are projected not to have an amount credited to them that is sufficient to pay that year's benefits. A third measure summarizes the expected adequacy of trust fund balances over a specific projection period. The 75-year actuarial deficit is the difference between annual costs and income, expressed as a percentage of taxable payroll, summarized over the period. The table below provides the Congressional Budget Office's estimates of those yardsticks under the current rules for calculating benefits and under each of the three options for Social Security that are presented in this chapter.

By any of those yardsticks, the Social Security program's long-term financial outlook is not good. In 2017, projected outlays for Social Security will begin to exceed the tax revenues earmarked for the program. Once that happens, the federal government will need to draw on other resources to fund Social Security, even though the program's combined trust funds will continue to be credited with interest on the balances. The trust funds themselves are projected to be depleted in 2041. The 75-year projected actuarial deficit in the trust funds is nearly 2 percent of taxable payroll—meaning that the present value of the projected financial obligations of the program over that period substantially exceeds the present value of the resources projected to be available to the program under current law. According to the program's actuaries, an immediate, permanent 15 percent increase in the payroll tax or an equivalent reduction in benefits would be needed to eliminate that deficit.

Each of the three illustrative options discussed in this chapter would improve the program's outlook, but only the option of constraining the increase in initial benefits would reduce the growth in costs by enough to ultimately close the gap between costs and income, prevent the trust funds from being depleted, and eliminate the 75-year actuarial deficit. The options of raising the normal retirement age and reducing the cost-of-living adjustment would delay the date at which the trust funds were depleted and would substantially reduce the actuarial deficit, but additional steps—to slow the growth in benefits or to increase resources earmarked for the program—would be required to bring the program's finances into balance.

	Current Law Base Case	Constrain the Increase in Initial Benefits	Raise the Retirement Age	Reduce the COLA
Cost/Income Gap (Percentage of taxable payroll)				
2002	1.83	1.83	1.83	1.83
2030	-4.02	-2.30	-2.60	-2.46
2050	-4.64	-0.89	-2.02	-2.79
2075	-6.37	0.46	-2.54	-4.28
First Year in Which Costs Exceed Noninterest Revenues	2017	2019	2019	2020
First Year in Which Combined OASDI Trust Funds Are Depleted	2041	n.a.[a]	2064	2063
75-Year Actuarial Deficit of the Combined OASDI Trust Funds (Percentage of taxable payroll)	-1.89	0.28	-0.39	-0.58

Source: Congressional Budget Office.

Note: COLA = cost-of-living adjustment; OASDI = Old-Age and Survivors Insurance and Disability Insurance programs.

a. Not applicable because under this option, the trust funds would not be depleted within the 75-year projection period.

Figure 4-1.

Federal Spending Under Illustrative Options for Slowing the Growth in Social Security

(Percentage of GDP)
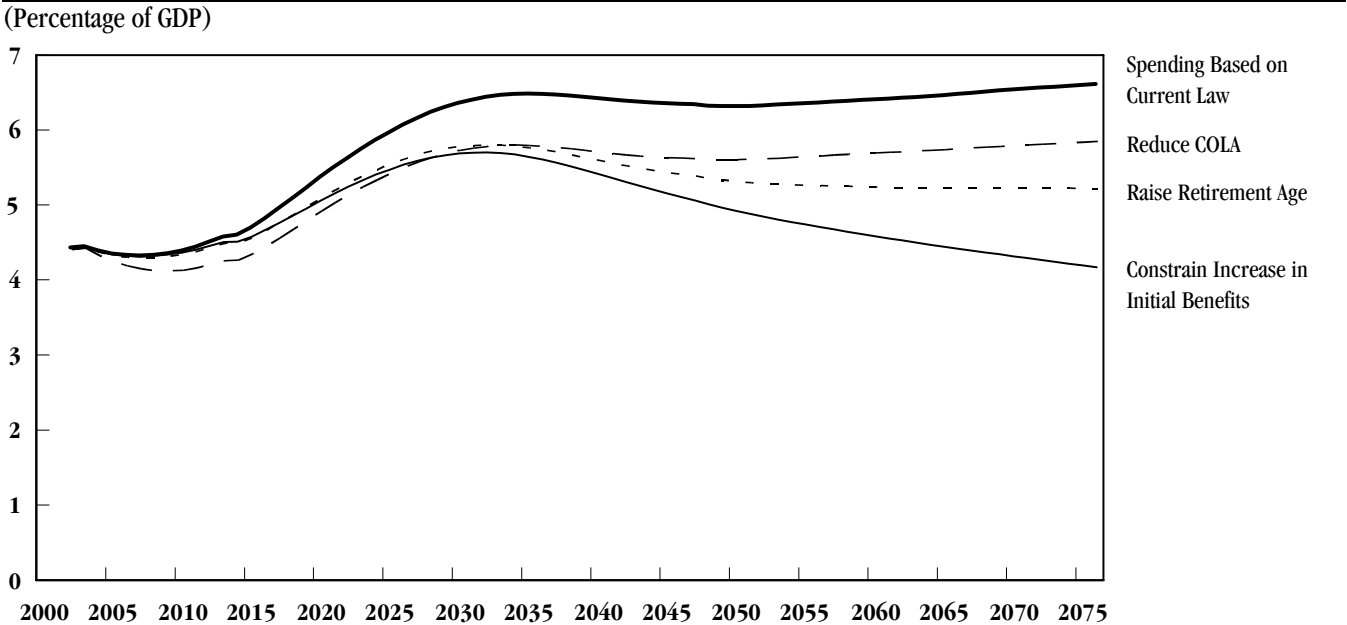
Source: Congressional Budget Office.

Note: See the text of this chapter for descriptions of the illustrative options.

The option to constrain the rise in initial benefits by linking their growth to a price index rather than to a wage index would achieve the largest savings because once it was fully implemented, the nominal growth in Social Security benefits would no longer respond to the general growth in real wages in the economy. Thus, by 2075 projected spending for Social Security benefits as a share of GDP would be 4.2 percent of GDP (slightly below its current share) instead of rising to 6.6 percent, as projected under current law (*see Figure 4-1 and Table 4-2*). Neither of the other illustrative options would reduce the growth in benefits by enough to prevent outlays for the program from becoming a significantly larger share of national income once the baby-boom generation retired. The option for increasing the normal retirement age would cut projected spending in 2075 by about 1.4 percent of GDP. Reducing the COLA would cut projected spending by about 0.7 percent of GDP.

Considering Social Security, Medicare, and Medicaid together, CBO projects that, under current policies, the costs for the programs will increase from about 8 percent

Table 4-2.

Effects of Illustrative Options for Reducing Growth in Spending for Social Security

(Percentage of GDP)

	2002	2030	2050	2075
Current-Law Base Case	4.4	6.3	6.3	6.6
Effects of Illustrative Options				
Constrain the Increase in Initial Benefits	n.a.	-0.7	-1.4	-2.4
Raise the Retirement Age	n.a.	-0.5	-1.0	-1.4
Reduce the COLA	n.a.	-0.6	-0.7	-0.7

Source: Congressional Budget Office.

Notes: n.a. = not applicable; COLA = cost-of-living adjustment.

See the text of this chapter for descriptions of the illustrative options.

The effects of each illustrative option are considered in isolation; if joined together, the options would interact in ways that would reduce the combined savings.

this year to 21 percent by 2075. Even though constraining the increase in initial benefits in the Social Security program by linking their growth to a price index—the illustrative option producing the largest savings—would solve that program's long-term fiscal problem, it would eliminate only about one-fifth of the projected increase in spending for the three programs combined. The other illustrative options would each make a notably smaller contribution toward slowing the growth in spending for all three programs. Additional savings could be achieved by combining the options, but doing so would further reduce the income of Social Security recipients.

Medicare

After changes in the reimbursement of providers were imposed under the Balanced Budget Act of 1997, per capita Medicare spending remained stable between 1997 and 1998, and it actually fell by nearly 2 percent in 1999. In 2000, it grew by only 2 percent. But that slowdown in spending was short-lived. The growth in per capita spending resumed higher levels in 2001.

CBO expects that growth to continue at high levels in the future, causing Medicare spending to increase from 2 percent of GDP today to about 9 percent in 2075. That long-term projection is based on demographic forecasts similar to those used by the Social Security Administration's actuary; and it assumes that spending growth per beneficiary from 2028 through 2075 will decline to 1 percentage point above the growth in per capita GDP—which is similar to the intermediate assumption made by the trustees of the Medicare trust funds. That projected rate of growth is considerably lower than the historical rate of growth for Medicare.[11] Although CBO's projection is intended to reflect the path of spending under current law, it is based on the assumption that the private sector will act to constrain health care costs and that, in the long run, Medicare spending will have the same per capita growth rate as private health care.

The same demographic trends contributing to growth in Social Security spending will drive long-term growth in Medicare spending. The Medicare population will expand rapidly as baby boomers retire and as longevity continues to extend. Increases in the cost of the program per person will add to Medicare's long-term cost growth.

Medicare's payment schemes under its fee-for-service program, which covers approximately 88 percent of enrollees, create incentives for health care providers to increase the volume of services that they furnish. For each service (or bundle of services) from providers, Medicare makes a payment, so providers that are successful in increasing their volume of services increase their revenues. The program has limited ability to control through the payment system the total number of services furnished; instead, it generally can only set the amount of payment per service. That problem, driven by the volume of transactions, is most serious in physician services, although it also exists for durable medical equipment and laboratory services and other types of providers as well.[12]

Two broad approaches might be used to reduce federal spending on Medicare in the future:

- Reducing the number of people who are eligible for benefits and

- Lowering Medicare's costs per eligible person.

Reducing the number of people who are eligible for benefits is a matter of determining which individuals would be affected and when to implement the change. Lowering Medicare's costs per person could be achieved in several ways. One would be to shift more expenses to enrollees by raising premiums or boosting cost sharing. Another way would limit what Medicare contributes toward health care expenses. A defined contribution could

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11. For example, from 1970 to 2000 Medicare spending per beneficiary grew at an annual rate of about 3 percentage points above the annual growth in per capita GDP. Per capita spending on health care historically has risen faster than per capita GDP as a result of the introduction of new technology and muted concern by consumers about its cost because of insurance coverage.

12. The Congress and the President have enacted legislation directed at controlling the volume of physician services (and thus the total payments to physicians) through a mechanism called the sustainable growth rate. That mechanism adjusts the payment rate per service to reflect the overall volume of services that has been furnished in the past, relative to a target. If the volume of services exceeds the target, payment rates will be reduced; conversely, if the volume of services comes below the target, payment rates will be raised.

strengthen consumers' and providers' incentives to seek efficient modes of care. Depending on the level of the benefit and the responses of consumers, providers, and health plans, such an approach could but would not necessarily increase the costs borne by beneficiaries. A related approach would be to stimulate private health plans to compete through premiums to a greater extent than they do under current policies. Under competition, enrollees could have the incentive to join the health plans that provided benefits at the lowest cost while maintaining acceptable quality. Another possibility for lowering Medicare's costs per eligible person would be reducing payments to providers.

All of the approaches discussed in this chapter would lower total spending below the level to which it would rise under current policies, but most of the approaches would not change the rate of growth over time. For example, reducing the number of people eligible for Medicare would decrease spending by the amount that those people would have cost the program each year, but the rate of increase in spending for the remaining Medicare population would still be driven by the same factors as before—population growth and per capita increases in spending. However, some approaches, such as introducing more competition, would have the potential to slow growth if they changed incentives for health plans, providers, and enrollees to encourage them to use less—or less expensive—health care.

As in the Medicare program, federal expenditures for Medicaid will grow significantly after the baby boomers reach retirement age. Medicaid is a federal/state program that, like Medicare, provides health coverage to a target population that includes Medicare enrollees who are poor or have medical costs that consume much of their income. Certain Medicare beneficiaries who are very poor or who spend a significant portion of their income on medical care qualify for full Medicaid coverage, which provides not only payments for Medicare premiums and cost sharing but also services not covered by Medicare, such as prescription drugs and long-term care. Other poor Medicare beneficiaries with somewhat higher income have more limited Medicaid benefits, consisting of payments to cover Medicare premiums and cost sharing or the premiums only.

This chapter does not provide options to constrain Medicaid spending, but several options for the program appear in Chapter 2. Because many opportunities for cost cutting lie with the states, which have primary management responsibility for Medicaid and considerable discretion in tailoring their Medicaid plans, federal policies for reducing Medicaid spending are limited primarily to reducing the federal contribution to the program and restricting the coverage options available to the states. Both are approaches that have encountered strong resistance from state governments. Another option would convert to a block grant supplemental payments to hospitals that serve large numbers of the poor and uninsured.[13]

Over the past decade, many states have expanded eligibility for Medicaid and benefits far beyond federally mandated levels. In a climate of cost reduction, states could reduce rates for payments to providers, cut back on eligibility standards, trim enrollment through decreased outreach, and reduce the scope of benefits provided under the program. States could also increase cost sharing for Medicaid beneficiaries, but only to a modest extent because of federal limits. In any case, given the income levels of Medicaid beneficiaries, the potential savings from increasing cost sharing are modest at best. (*See Box 4-2.*)

Background on Medicare

Medicare provides federal health insurance for 40 million people who are aged or disabled or who have end-stage renal disease. Part A of Medicare, or Hospital Insurance (HI), covers inpatient services provided by hospitals as well as skilled nursing, home health, and hospice care. Part B, or Supplementary Medical Insurance (SMI), covers services provided by physicians, limited-licence practitioners (such as chiropractors and podiatrists), hospitals' outpatient departments, home health agencies, and suppliers of medical equipment.

Everyone who is eligible for Social Security benefits on the basis of age or disability is ultimately eligible for Medicare as well. For early retirees, eligibility for Medicare is delayed until age 65. Similarly, after they become eligible for Social Security, disabled enrollees must wait two years to become eligible for Medicare. In addition,

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13. See option 550-05.

Box 4-2.

Medicaid and Long-Term Care

As with the Medicare program, federal expenditures for Medicaid are projected to grow significantly as the baby boomers begin reaching age 65 in 2011, but the most significant growth for the Medicaid program will probably materialize around 2030—when baby boomers begin to join the ranks of the "oldest old" (those age 85 or older) and many of them begin to need long-term care services.[1] The potentially large future demand for long-term care services poses a major challenge for federal policymakers and for the economy. Spending from all sources for nursing home and home-based services for seniors is expected to exceed $120 billion in 2002 (see the table). Increasing costs are driven by both the growing number of senior citizens and higher costs for care. By 2040, spending on long-term care is projected to reach $346 billion (in 2000 dollars), or 1.5 percent of gross domestic product (GDP), up from 1.2 percent of GDP in 2002.

The Use of Long-Term Care Services by the Elderly

Long-term care comprises a variety of medical and social services for elderly and disabled people whose disabilities prevent them from living independently. Formal long-term care services may be provided in the home or community or in institutions for those who can no longer remain in their homes. Not all people who could use such services receive them, however, because formal services are costly and may be less desirable than informal help from family and friends. Indeed, the most important sources of assistance for disabled elderly people who remain in the community are live-in caregivers and networks of family helpers.

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1. While a significant number of people under age 65 are disabled and consume long-term care services, the bulk of such care goes to the elderly.

Long-Term Care Expenditures for the Elderly, by Source of Payment, 2002
(In billions of dollars)

	Institutional Care	Home Care	All Long-Term Care
Third-Party Payers			
Medicaid	34.8	7.0	41.9
Medicare	13.5	15.2	28.7
Private insurance	2.5	3.7	6.2
Out-of-Pocket Payments	33.5	5.7	39.2
Other	1.2	3.6	4.8
Total	**85.5**	**35.2**	**120.8**

Source: Congressional Budget Office based on data from the national health accounts, the Medicare Current Beneficiary Survey, the Medical Expenditure Panel Survey, and the Centers for Medicare and Medicaid Services and from the long-term care financing model prepared by the Lewin Group for the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

Despite recent rapid growth in spending for long-term care, most services are still provided informally and are not, therefore, represented in the data on expenditures.

In 1999, about 6.6 million seniors (or about 19 percent of the elderly population) required assistance because of physical or cognitive impairments. Of that number, 1.7 million were in nursing homes, and 1 million were severely disabled but still living in the community, although they probably would have qualified for admission to a nursing home. The remainder were less severely disabled but still potential users of long-term care services.

Box 4-2.

Continued

Over the next 30 years or so, the elderly population will double, a level of growth that is also foreseen for the "oldest old" population, which of course is made up of people who are more likely to have disabilities that make them depend on others for assistance. In 2030, the number of seniors who are disabled is projected to be more than 12 million. Although the prevalence of disability among the elderly appears to be on the decline, the large increase in the number of people age 85 or older will more than offset that favorable trend. Those estimates are quite speculative, however, because of the uncertainty that surrounds future rates of disability and longevity among the elderly.

Another uncertainty affecting the future demand for formal long-term care services is whether or not informal caregivers will continue to provide as much care as they do now.

Financing Long-Term Care for the Elderly

The future growth of spending on long-term care for the elderly has major significance for the federal budget as well as the overall economy. Medicare and Medicaid, the two largest public financing programs, paid for more than half of nursing home and home care expenditures for the elderly in 2002. Medicare pays primarily for medical treatment for acute health problems but has become a de facto provider of long-term care through its coverage of home health care and services in skilled nursing facilities. Although that coverage was originally intended to meet the short-term needs, Medicare's home health benefit is increasingly important for chronic care patients. During the latter part of the 1990s, Medicare spending for home health care fell in response to several factors, including changes in the reimbursement methodology and a crackdown on fraud and abuse, but such spending resumed its steady growth in 2000.

The federal government is the principal payer of formal long-term care services for the elderly. That financing role steadily expanded in the 1990s as a result, in part, of a rapid rise in Medicare spending for skilled nursing facilities and home health services. In 2002, the federal government accounted for about 45 percent of all spending on nursing home and home care for the elderly and about 75 percent of the public expenditures for those services.

By contrast, the role of private insurance in financing long-term care is small, though growing; in 2002 it accounted for about 5 percent of all spending on nursing home and home care for the elderly.[2] Less than 10 percent of seniors have private long-term care insurance, but employers, including the federal government, are increasingly facilitating such coverage as an employee benefit. However, employees typically must pay the total premium. Without a major expansion of the market for private long-term care insurance, the federal government's responsibility for financing long-term care is likely to continue to grow. Yet the use of such services would probably rise significantly if a large percentage of the population had long-term insurance—especially if those policies covered in-home services.

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2. Payments by private insurance may be underreported because most insurers reimburse policyholders for costs that they have already incurred and paid, rather than paying providers of services directly. As a result, those payments by insurers may be reported as out-of-pocket spending rather than as spending by private insurance.

people who are 65 or older and not eligible for Social Security benefits may enroll in Medicare by paying premiums. In total, 96 percent of the U.S. population age 65 or older is enrolled in Part A; 92 percent is enrolled in Part B.

Hospital Insurance benefits are financed primarily from current workers' payroll taxes. Supplementary Medical Insurance is financed from two sources: 25 percent comes from enrollees who pay premiums, and 75 percent comes from general revenues.

Medicare requires enrollees to pay part of the cost of most covered services through various arrangements and to various degrees. Inpatient hospital stays, for example, require patients to first pay a deductible ($840 per benefit period in 2003) and then pay additional daily copayments if they have more than 60 days of care. Part B services require a $100 deductible per year. For physician and other medical services, patients generally pay 20 percent of the Medicare-approved amount after they meet the deductible. Some services require no cost sharing, namely, laboratory, home health, and selected preventive services.

The federal government and state governments incur additional health care costs for the Medicare population through Medicaid. Because of the overlap in coverage between Medicare and Medicaid, efforts to control Medicare spending generally will affect Medicaid spending; the magnitude and direction of the effect, however, will depend on the specifics of each proposal. For example, increasing Medicare's cost-sharing requirements would raise Medicaid spending, but lowering Medicare's payments to providers would lower Medicaid spending.

Other governmental and private entities also incur health care costs for Medicare enrollees. Government benefits programs, available through the Federal Employees Health Benefits program and the Departments of Defense and Veterans Affairs, for example, provide health care coverage or services to eligible enrollees.[14] Approxi-

mately 33 percent of Medicare enrollees have supplemental coverage provided by a former employer or union. Another 23 percent of Medicare enrollees pay for individual supplemental insurance, or medigap. Such supplemental coverage typically pays for much of Medicare's cost sharing and occasionally for some items that Medicare does not cover, such as prescription drugs.

As described, most Medicare enrollees receive their care through a fee-for-service system. But 12 percent receive their care through private health plans (usually HMOs [health maintenance organizations]) that agree to take on the insurance risk for all Medicare benefits in exchange for a predetermined monthly payment. Operating under the Medicare+Choice (M+C) program, all plans receive payments that are based in part on historical costs in the fee-for-service sector, but they are guaranteed a minimum (floor) payment. If a plan's cost of providing Medicare benefits is less than the capitated payment it receives, it must return all of the excess to enrollees by covering additional benefits or by providing a rebate (which is limited to the amount of the Part B premium). M+C plans have typically offered enrollees lower cost sharing than that required under the fee-for-service system and often have enhanced the benefit package to include services that Medicare does not cover.

Approaches and Illustrative Options for Slowing the Growth of Medicare Spending

Two broad approaches could slow the growth in federal spending for Medicare: reducing the number of people who are eligible for benefits or reducing the costs per enrollee. Within those two approaches, the illustrative options discussed in this chapter could be combined to generate even more savings.

All of the options involve difficult choices and political challenges. Reducing the number of people who are eligible or reducing the government's costs per enrollee by increasing the share of costs paid by enrollees would shift costs from the Medicare program to those people who

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14. Under the Department of Defense's TRICARE for Life program, created in 2000, eligible people age 65 or older receive generous coverage of cost-sharing amounts within the Medicare program,

as well as coverage of prescription drugs. Because that supplemental coverage insulates enrollees from having to pay for any of the costs of services, Medicare spending for this population tends to be relatively high.

had lost their coverage or to enrollees (or to the government programs or insurance companies that paid the cost sharing for them). Reducing costs through competition offers the potential for savings through greater efficiency, though beneficiaries who do not wish to join private health plans might face higher premiums than those to which they have been accustomed.

The timing of changes to the program is important from both a budgetary and a policy perspective. The longer legislators postpone changes designed to slow spending, the lower the impact that those changes will have on total spending over time. As with changes to Social Security, equity and efficiency argue for announcing any changes long before they take effect so that people have more time to plan and adjust to the changes.

Reduce the Number of Enrollees by Raising the Age of Eligibility. The number of people who are eligible for Medicare could be reduced by gradually raising the age of eligibility, as two options presented here show. The first would gradually increase the age of eligibility for Medicare from 65 to 67 by 2026, to be consistent with currently scheduled increases in the normal retirement age for Social Security benefits. Although the gradual increase has already begun in the Social Security program, this option assumes that the increase in the age of eligibility for Medicare would not start until 2015, to allow people who are currently nearing retirement the time to plan and adjust. Beginning in 2015, the eligibility age would increase by two months every year until it reached 67 in 2026, where it would remain in future years.

The second option assumes that the eligibility age would increase by two months every year beginning in 2015 until it reached 70 in 2044, where it would remain. This option is analogous to the one that would raise the normal retirement age for Social Security (described earlier in this chapter), but it would be phased in more slowly and would not raise the eligibility age above 70.

According to CBO's estimates, the first option, once it was fully in place, would reduce Medicare's enrollment by about 7 percent and net spending by about 3 percent a year, compared with what they would be under current policies. Spending is projected to fall by less than enrollment is because people who are 65 or 66 are typically the least costly enrollees. By 2075, the reduction in net spending for Medicare would be about 0.3 percent of GDP. The second option, once it was fully in place, would reduce Medicare's enrollment by about 17 percent and net spending by about 9 percent a year. By 2075, the reduction in net spending for Medicare would be about 0.7 percent of GDP.

The reduced spending for Medicare would be partially offset by increased spending under Medicaid and the Federal Employees Health Benefits program—both of which would have to pick up part of the health care costs of their beneficiaries whose eligibility for Medicare had been delayed.[15] However, spending would be reduced for the military's TRICARE for Life program, because eligibility for that program is limited to people who are enrolled in Medicare. The effects of raising the Medicare eligibility age on federal spending for these three programs through 2075 are not estimated here. However, to provide an indication of the likely effects, CBO estimates that raising the Medicare eligibility age to 67 or to 70 by 2013 would result in an increase in the combined spending for those three programs equal to about 13 percent to 14 percent of the savings for Medicare.

Although raising the age of eligibility would reduce Medicare spending, it would do little to reduce total health care costs for those eligible for Medicare under current law. Further, it would lengthen the period of time during which those opting for early retirement under Social Security (at age 62) might have difficulty getting insurance coverage. That disadvantage could be lessened by coupling this approach with an option under which early retirees could buy Medicare coverage by paying an actuarially fair premium. Such coverage would be costly, however, and designing it so that it was budget neutral would be difficult because of the need to account for the fact that the people who participated would be expected

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15. Raising the eligibility age would also increase state spending for Medicaid because about 17 percent of Medicare enrollees receive Medicaid benefits as well.

to have a greater demand for medical care than those who did not participate.[16]

Increasing Medicare's eligibility age would shift costs that are now paid by Medicare to enrollees and to employers. The higher costs to employers might reduce the number of them who offered health benefits to retirees, thereby accelerating a current trend. Another effect might be to increase the number of applications for disability from the affected population, which would reduce the savings that Medicare would otherwise realize; that effect is not estimated here.

Decrease Medicare's Costs per Person by Raising Monthly Premiums. One way to decrease Medicare's costs per person would be to increase enrollees' premiums (see options 570-12 and 570-13 in Chapter 2). Premiums paid by Medicare's SMI enrollees now cover about 25 percent of the average benefits paid through that program, although the premiums were intended to cover 50 percent of the costs for SMI when Medicare was first established. Increasing collections from all enrollees to cover that percentage would reduce net Medicare spending by about 12 percent, or 1.0 percent of GDP, in 2075.

If premiums were higher for all enrollees, the increase could impose a financial hardship on lower-income enrollees who were not eligible for Medicaid. In addition, it would raise Medicaid's costs for Medicare enrollees who were also receiving Medicaid benefits, since Medicaid pays the Medicare premiums for those people. The resulting increases in federal spending for Medicaid would offset the net savings for Medicare by less than 0.1 percent of GDP. Another likely consequence would be lower participation in Part B by people with alternative coverage, including coverage through federal programs like the Federal Employees Health Benefits program, and

thus higher costs in those programs. Such costs are not estimated here.

One alternative would vary the amounts that Medicare collected from enrollees on the basis of their financial resources (necessitating a process for determining enrollees' income). For example, premiums could be higher for enrollees with the highest income and the same as they are under current law for all other enrollees. Under the option presented here, individuals with an adjusted gross income of less than $50,000 (in 2003 dollars) would pay the Part B premiums now prescribed by law. For higher-income people, premiums would rise, reaching a maximum of twice the current premiums for individuals with an adjusted gross income of more than $100,000.[17] Those thresholds would be adjusted over time to hold the proportions of beneficiaries constant. This alternative would reduce net Medicare spending by about 0.1 percent of GDP by 2075. A result would be higher implicit marginal tax rates for Medicare enrollees due to phasing out the subsidy for higher-income enrollees.

The premiums that Medicare enrollees now pay average about 2 percent of their income and are projected to rise to nearly 6 percent on average by 2075. If premiums rose to cover 50 percent of SMI costs, Medicare premiums on average would amount to about 12 percent of enrollees' income by 2075. Under the option in which premiums would be higher only for the wealthiest individuals, premiums on average would be about 7 percent of enrollees' income by 2075. Those costs for enrollees could be reduced only if the growth in health care costs slowed to a greater extent than the projections assume.

Increasing premiums would reduce net federal spending for Medicare but only by shifting more costs to enrollees or their secondary payers. It would do little or nothing to lower beneficiaries' use of health care.

Decrease Medicare's Costs per Enrollee by Raising Cost Sharing for Services. Another way to increase the portion of costs that enrollees pay would be to raise cost sharing for services (see options 570-14, 570-15, 570-16,

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16. Because of that anticipated "adverse selection," the Clinton Administration's proposal to allow people ages 62 to 64 to buy into Medicare called for a two-part premium. Before age 65, enrollees would have paid premiums that reflected the average expected cost of benefits if everyone ages 62 to 64 had participated in the buy-in. At age 65 and thereafter, participants would have paid a surcharge (in addition to the regular Medicare premiums) to account for the government's extra costs resulting from adverse selection in the buy-in program.

17. The adjusted gross income thresholds for couples would be $75,000 and $150,000 (in 2003 dollars).

570-17, 570-18, and 570-20 in Chapter 2). Raising cost sharing would both lower Medicare spending directly and make enrollees more sensitive to the costs of health services and thus more judicious in seeking those services. Increased cost sharing (as well as higher premiums for enrollees) has become more prevalent in the design of private-sector plans over the past several years, as insurers try to limit premium increases for purchasers. Studies have found that higher cost sharing generally reduces the use of services with little effect on health outcomes, with the notable exception of patients with low income and certain health conditions.[18]

Cost sharing could increase in a number of ways to support a variety of policy goals. For example, increases could be targeted toward services that are used relatively frequently at enrollees' election, such as doctor's visits. Or greater cost sharing could be more broadly applied, such as through higher deductibles, regardless of the type of services used. Copayments—fixed dollar payments per service—have the advantage of giving Medicare enrollees a predictable amount of cost sharing, while coinsurance —a fixed percentage of a bill—sends a clearer price signal about the relative costliness of providers (to the extent that fees are permitted to vary). Private-sector plans are experimenting with ways to simultaneously raise cost sharing and send clearer price signals about the costs of different health care providers.[19]

Although, in principle, cost-sharing requirements can encourage enrollees to be more prudent consumers of health care, that effect is likely to be weak in the Medicare program because so many people have supplemental coverage that pays for cost sharing. Consequently, they would not directly experience the higher costs. The result would be primarily a shift in costs rather than a reduction in the use of services. To be effective at deterring the use of services, such a policy would need to be combined with rules that limited supplemental coverage.

Medicaid pays cost sharing for most Medicare enrollees who are also eligible for Medicaid, although states may require enrollees to pay nominal cost-sharing amounts. Thus, increases in cost sharing for Medicaid enrollees would only shift costs to the states rather than reduce total spending.

Medigap plans typically cover most of Medicare's cost sharing. If Medicare increased cost sharing and medigap plans could pick up the additional amounts, enrollees would pay for the increases in higher medigap premiums rather than through higher out-of-pocket spending when they were deciding whether or not to use health services. For that reason, medigap supplemental coverage would dampen the savings from higher cost sharing.

Other types of supplemental Medicare coverage pose a similar constraint on the effectiveness of increasing cost sharing. Medicare HMOs and employer-based plans typically have lower cost-sharing requirements than Medicare has. However, both types of supplemental coverage have increased cost sharing in recent years.[20]

Short of increasing Medicare's cost sharing requirements, changes to medigap alone that would expose enrollees to at least some of Medicare's existing cost sharing would generate savings. Enrollees would likely lower their use of some discretionary services if they had to pay more for them. Even greater savings would be realized by prohibiting all private supplemental insurers from paying for Medicare cost sharing.

18. Robert H. Brook and others, "Does Free Care Improve Adults' Health?" *The New England Journal of Medicine*, vol. 309, no. 23 (December 8, 1983), pp. 1426-1434; W. Manning and others, "Health Insurance and the Demand for Medicaid Care: Evidence from a Randomized Experiment," *American Economic Review*, vol. 77, no. 3 (June 1987), pp. 251-277.

19. James C. Robinson, "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design," *Health Affairs* (March 20, 2002), pp. W139-W154, Web issue available at www. healthaffairs.org.

20. For a discussion of the increase in cost sharing in employer-based plans, see The Henry J. Kaiser Family Foundation and Hewitt Associates, *The Current State of Retiree Health Benefits* (December 2002). For information on the trend toward increased cost sharing in HMOs, see Marsha Gold and Lori Achman, "Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999-2001" (issue brief prepared for The Commonwealth Fund, April 2001), available at www.cmwf.org.

Introduce Greater Competition. Restructuring the Medicare market to introduce greater competition could reduce costs per enrollee. The option presented here would set up a system in which plans would compete for enrollees on the basis of premiums and other attributes such as quality of care and customer service. The system would include private plans such as HMOs and preferred provider organizations as well as providers in Medicare's traditional fee-for-service sector. But Medicare's payments would be determined through competitive market forces rather than through administered pricing. Furthermore, unlike arrangements under the current M+C payment system, Medicare would capture some of the savings if private plans provided Medicare benefits more efficiently than the fee-for-service sector did.

In 1999, the Bipartisan Commission on the Future of Medicare developed a proposal for reform based on competition, but the proposal did not receive enough votes among the commission's members for it to be presented as a formal recommendation to the President and the Congress. Subsequently, some members of the commission introduced a bill, S. 357, based on the commission's proposal. Other proposals for reforming Medicare through competition (which differ in important ways from S. 357) include the Clinton Administration's proposal, a proposal passed by the House in 2002 (H.R. 4954), and a bill introduced in the Senate in 2001 (S. 358).

In the option presented here, all participating plans would be required to offer a standard benefit package. Medicare would make a contribution toward the premiums of each plan up to a maximum amount, called the reference premium, or benchmark. Plans' premiums and perhaps the benchmark as well would be determined through competitive bidding. Beneficiaries would be required to pay premiums above the benchmark and would receive rebates for enrolling in less expensive plans. Plans would be permitted to offer supplemental benefits for which beneficiaries would pay an additional premium.

Such a competitive bidding system could reduce Medicare's costs by altering the incentives facing both beneficiaries and plans. Requiring beneficiaries to pay higher premiums for enrolling in more expensive plans would encourage them to be more cost-conscious in their selection. Competitive forces would therefore encourage plans to keep premiums low.

But whether or not a restructured market produced significant savings for Medicare would depend on how it was designed and on how beneficiaries and plans responded. A key design decision would be how to set the benchmark. One approach would be to base the benchmark on the bids submitted by plans, with the bids from all plans treated on an equal basis. For example, the benchmark could be set to equal the minimum or average bid in a market area or the national average bid, which would include the average cost in the fee-for-service sector.

A second approach would be to set the benchmark to equal the average cost in that sector. This approach would give special status to the fee-for-service sector and would guarantee that beneficiaries in that sector would never pay higher premiums than the Part B premiums—even if the care in that sector was the most expensive option available. The approach would therefore have less potential for reducing Medicare spending.

A third approach would be to set the benchmark independently of the actual costs of health plans, initially on the basis of a budgetary target, and then to update it by a predetermined amount (for example, the annual growth in per capita GDP). Medicare could be certain of controlling its spending under this approach because the financial risks posed by the growth in health care costs would shift to plans—and ultimately to beneficiaries through premiums. However, if health care costs grew faster than the annual update in the defined contribution, beneficiaries could face very large increases in their premiums. This approach is analogous to the defined-contribution approach that some employers are considering.

The effects of a competitive bidding system on Medicare spending would also depend on whether private plans could provide Medicare benefits more efficiently than the fee-for-service sector could and on whether those differences in efficiency were revealed through plans' bids. There is evidence that HMOs provide care at a lower total cost than do other types of plans because those organizations use hospital services and other expensive

resources less. However, in recent years, in response to a backlash from consumers, some plans have eased their restrictions on care, and providers have gained greater leverage with HMOs in their contract negotiations. Those circumstances suggest that the cost advantages enjoyed in the past by HMOs have diminished, at least temporarily.

Beneficiaries' preferences—and particularly their willingness to switch plans in response to differences in premiums—would also play an important role in determining whether a competitive bidding system significantly reduced Medicare spending. Plans would be more likely to bid aggressively if doing so enabled them to capture a substantial share of the market. The limited evidence on the price responsiveness of Medicare beneficiaries suggests that they respond much less to differences in premiums than people under 65 do, but additional research on the topic is needed to draw definitive conclusions.

Implementing a competitive bidding system would pose many challenges. First, the payment system would have to include an effective mechanism to compensate for the fact that some plans would be likely to attract enrollees who were healthier than average, while others would be likely to attract enrollees with below-average health. An effective risk adjustor would pay plans fairly for the people they enrolled and would minimize the chance that plans would try to compete on their ability to attract enrollees who were "good risks."[21] Another challenge would be educating beneficiaries about the new system and about the costs and quality of the available health plans. In addition, it would be necessary to determine whether and how benchmarks should reflect geographic variations in Medicare's costs, which reflect differences in utilization as well as prices and other factors. Finally, a method for setting the government's contributions in geographic areas with few competing plans would be needed.

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21. Medicare will implement a new risk adjustor for managed care plans that will incorporate information on the health status of enrollees derived from their previous encounters with the health care system. Although the new risk adjustor is expected to be a significant improvement over the current one, whether or not it will be adequate is unknown.

All in all, the effect of a competitive bidding system on Medicare spending is highly uncertain because of questions about how plans and beneficiaries would respond. Presumably, a properly designed competitive system would lead to greater efficiency and reduced spending. However, there is insufficient evidence to predict with confidence the magnitude of any reduction in spending. For example, it is not known how the bids of private plans would compare with average spending in the fee-for-service sector and whether vigorous competition would emerge in many geographic areas. Moreover, there is great uncertainty about whether, after being fully implemented, a competitive system would reduce the level of Medicare spending per enrollee and whether the long-term growth of spending per enrollee would be reduced as well.

If the competitive system reduced Medicare spending per enrollee by 5 percent but did not change the growth in spending per enrollee, in 2075 net spending on Medicare would be reduced by about 0.4 percent of GDP. However, if the competitive system initially reduced spending by 5 percent and also reduced the growth in spending per enrollee from the projected 5.4 percent a year to, say, 5.0 percent a year, in 2075 net Medicare spending would be reduced by about 2.0 percent of GDP—illustrating the power of compounding over a long period even when a policy option reduces the growth in spending by only a modest amount. The proportion of the savings that would come from lower payments to plans versus higher premiums paid by beneficiaries would depend on the design of the competitive system and the willingness of beneficiaries to switch plans in response to differences in premiums.

Reduce per Capita Spending Using Other Strategies. Other approaches for reducing Medicare spending that affect aspects of the current fee-for-service program include reducing payments to providers and introducing coverage of disease or case management—programs that coordinate care among providers, ensure that patients comply with their treatment regimens, and encourage health care providers to adhere to evidence-based guidelines.

Reduce Provider Payments. Over Medicare's history, the Congress often has changed payments to health care

providers to slow the growth in per capita spending—often lowering the increase, or update, to the annual payment rate that would have otherwise applied (see options 570-07, 570-08, and 570-19 in Chapter 2). That sort of strategy might be effective in generating savings in the short run but would do little to address the underlying sources of spending growth. Further, such changes would tend not to be sustainable, since formulas for updates are based on increases in providers' costs. If payments did not keep pace with overall cost increases, reducing provider payments could restrict Medicare enrollees' access to health care: because Medicare limits the amount that providers may charge enrollees over and above the program's payment rate, if the total amount that providers were allowed to charge was below their marginal cost of providing services, they could restrict Medicare patients' access to care.

Introduce Disease Management and Case Management. Proponents of disease management and case management claim that adding those benefits to Medicare will improve the quality of care that enrollees receive and lower federal costs at the same time. Because Medicare's expenditures are concentrated among a small number of high-cost enrollees (for whom expenditures often persist over time), savings could come from preventing the use of expensive services by better coordinating existing resources or using preventive care. For example, a disease management program for patients with diabetes could ensure that enrollees received recommended foot and eye exams annually. By detecting problems earlier, such steps could prevent more-expensive treatments, such as hospitalization or surgery.

But whether or not disease management or case management can improve health outcomes, much less produce long-term savings, is not yet known.[22] The industry has developed programs that claim to improve the quality of care and to reduce costs, but the limited number of studies available and the methodological issues that they

present raise questions about those claims. Even if disease management and case management programs were found to save money, determining how the programs applied within Medicare would still be necessary.

Table 4-3.

Effects of Several Illustrative Options for Reducing Growth of Net Medicare Spending

(Percentage of GDP)

	2002	2030	2050	2075
Projected Gross Medicare Spending Under Current Policies	2.4	4.7	6.5	9.2
Less: SMI Premiums	0.2	0.6	0.7	1.0
Projected Net Medicare Spending Under Current Policies	2.1	4.2	5.8	8.2
Effects of Illustrative Options				
Raise the Eligibility Age				
To 67	n.a.	-0.2	-0.2	-0.3
To 70	n.a.	-0.2	-0.6	-0.7
Increase SMI Premiums				
Collect 50 percent of SMI costs from enrollees	n.a.	-0.6	-0.7	-1.0
Increase SMI premiums for upper-income beneficiaries[a]	n.a.	-0.1	-0.1	-0.1

Source: Congressional Budget Office

Notes: n.a. = not applicable; SMI = Supplementary Medical Insurance (Part B of Medicare).

The effects of each illustrative option are considered in isolation; if joined together, the options would interact in ways that would reduce the combined savings.

a. For this option, CBO assumed that individuals with an adjusted gross income (AGI) of less than $50,000 and couples with an AGI of less than $75,000 would pay the Part B premiums as prescribed under current law. Higher-income people would pay progressively higher premiums. The maximum (which would be paid by individuals with an AGI of more than $100,000 and couples with an AGI of more than $150,000) would be twice the premiums that exist under current law.

Income is expressed in 2003 dollars. CBO assumed that the income thresholds would grow at the same rate as the AGI among the Medicare population (that is, the proportions of the beneficiaries in each group would remain constant).

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22. Statement of Dan L. Crippen, Director, Congressional Budget Office, *Disease Management in Medicare: Data Analysis and Benefit Design Issues*, before the Senate Special Committee on Aging, September 19, 2002.

Conclusions About Medicare

Some of the options described in this chapter would have greater potential for reducing the growth in Medicare spending than would others. However, none of the options for which CBO developed long-range estimates would reduce the growth in spending by enough to prevent Medicare outlays from consuming a significantly higher share of GDP once the baby-boom generation retired. Among the options for which long-range estimates were presented, doubling the Part B premiums would achieve the largest savings, reducing net Medicare spending by 1.0 percent of GDP by 2075. However, net Medicare spending would still increase significantly under that option—from 2.1 percent of GDP today to 7.2 percent in 2075 (*see Table 4-3*). Increasing the eligibility age for Medicare to 70 would achieve smaller savings, reducing projected net Medicare spending in 2075 by 0.7 percent of GDP. Making inroads that would be significant enough to change the long-term outlook for Medicare could require a combination of approaches.